Coverage for: Individual or Family | Plan Type: POS

PRESBYTERIAN City of Rio Rancho Copay Plan

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-752-4164 or visit www.phs.org for Medical and 1-800-232-6549 or visit www.express-scripts.com for pharmacy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/or call 1-877-752-4164 to request a copy.

Important Questions	Answers	Why This Matters:	
What is the overall deductible?	In-network \$0 Out-of-network \$300 Individual \$600 Double \$900 Family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.	
Are there services covered before you meet your deductible?	Yes. <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This plan covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive care</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.	
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.	
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network \$1,000 Individual \$2,000 Double \$3,000 Family. Out-of-network \$3,500 Individual \$7,000 Double \$10,500 Family.	The <u>out of pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , They have to meet their own <u>out of pocket limit</u> until the overall family <u>out of pocket limit</u> has been met.	
What is not included in the out-of-pocket limit? Will you pay less if you use a network provider? Premiums, balance billing charges, health care this plan doesn't cover, and penalty amounts. Yes. See https://www2.phs.org/PHP_directory?insurance_plans=AH_PH or call 1-877-752-4164 for a list of participating providers.		Even though you pay these expenses, they don't count toward the out of pocket limit.	
		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out of network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).	
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.	

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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common		What You W	/ill Pay	Limitations, Exceptions, & Other	
Medical Event	Services You May Need	In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Important Information	
If you visit a health	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> /visit - adult /\$10 <u>copayment</u> /visit -child	30% <u>coinsurance</u> after <u>deductible</u> is met. Video visits- <u>deductible</u> may apply and <u>coinsurance</u>	\$0 copayment for virtual visits apply only to Onli Visits and TalkSpace Behavioral Health.	
	<u>Specialist</u> visit	\$40 <u>copayment</u> /visit	30% <u>coinsurance</u> after <u>deductible</u> is met	None	
	Preventive care/screening/immunization	No charge	30% <u>coinsurance</u> after <u>deductible</u> is met	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required.	
	Imaging (CT/PET scans, MRIs)	\$100 <u>copayment</u> /test per day	30% <u>coinsurance</u> after <u>deductible</u> is met		
	Generic drugs (Tier 1)	\$5 <u>copayment</u> (30-day retail)/ \$10 <u>copayment</u> (90-day mail order)	\$5 <u>copayment</u> (30-day retail)/ Not Covered (90-day mail order)	Tier 1, Tier 2 and Tier 3: Covers up to a 30-day supply (retail); 90-day supply (mail order prescription). Not all drugs are covered or have quantity limits. For more info go to www.express-scripts.com or call 1-866-217- 3774.	
If you need drugs to treat your illness or condition More information about	Preferred brand drugs (Tier 2)	\$35 <u>copayment</u> (30-day retail) /\$87.50 <u>copayment</u> (90- day mail order)	\$35 <u>copayment</u> (30-day retail)/ Not Covered (90- day mail order)		
prescription drug coverage is available at www.express-scrpits.	Non-preferred drugs (Tier 3)	\$55 <u>copayment</u> (30-day retail) /\$137.50 <u>copayment</u> (90-day mail order)	\$55 <u>copayment</u> (30-day retail)/ Not Covered (90- day mail order)		
<u>com</u>	Self-Administered Specialty (Tier 4)	Same cost as other generic, preferred brand, and non-preferred brand drugs	Not Covered	Please see the "Important Questions" section (page 1) of this document regarding the plan's out-of-pocket limit.	
		Visit www.express- scripts.com			

Common		What Yo	u Will Pay	Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Information	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copayment	30% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required.	
	Physician/surgeon fees	No charge	30% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required.	
	Emergency room care	\$100 copayment/visit	\$100 <u>copayment</u> initial visit	Out-of-network follow-up <u>Deductible</u> does apply and 30% <u>coinsurance</u> .	
If you need immediate medical attention	Emergency medical transportation	\$50 copayment/occurrence ground; \$100 copayment/occurrence air	\$50 copayment/occurrence ground; \$100 copayment/occurrence air	The member will be responsible for any balance due above Reasonable and Customary Charges for out-of-network air ambulance service.	
	Urgent care	\$40 copayment/visit	\$40 copayment/visit	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copayment/admission	30% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required.	
•	Physician/surgeon fees	No charge	30% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u> /visit - adult /\$10 <u>copayment</u> /visit -child	30% <u>coinsurance</u> after <u>deductible</u> is met	None	
	Inpatient services	\$500 copayment/admission	30% <u>coinsurance</u> after <u>deductible</u> is met	Prior authorization may be required.	
	Office visits	\$20 <u>copayment</u> /visit up to a maximum of \$200/pregnancy	30% <u>coinsurance</u> after <u>deductible</u> is met	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.	
If you are pregnant	Childbirth/delivery professional services	All delivery services are included	30% <u>coinsurance</u> after <u>deductible</u> is met	All services included.	
	Childbirth/delivery facility services	\$500 copayment/admission	30% coinsurance after deductible is met	Prior authorization may be required.	

Common	Services You May Need	What Yo	u Will Pay	Limitations, Exceptions, & Other Important	
Medical Event		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	Information	
	Home health care	\$40 copayment	30% <u>coinsurance</u> after <u>deductible</u> is met; 20% penalty applies if prior authorization not obtained.	Prior authorization may be required.	
	Rehabilitation services	Inpatient: \$500 copayment/admission; Outpatient: \$40 copayment/visit	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Coverage is limited to 80 visits/calendar year combined in- and out-of-network. Prior authorization may be required.	
If you need help recovering or have other special health needs	Habilitation services	Inpatient: \$500 copayment/admission; Outpatient: \$40 copayment/visit	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	None	
	Skilled nursing care	\$500 copayment/admission	30% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Coverage is limited to 60 days/calendar year combined in- and out-of-network. Prior authorization may be required.	
	Durable medical equipment	30% coinsurance	50% coinsurance after deductible is met; 20% penalty applies if prior authorization not obtained.	Prior authorization may be required.	
	Hospice services	No Charge	30% <u>coinsurance</u> after <u>deductible</u> is met	Waived if transferred directly from an inpatient hospital, rehabilitation, or skilled nursing facility. Prior authorization may be required	
	Children's eye exam	Included in office visit copayment	Not covered	Coverage is limited to refraction eye exam associated with post cataract surgery or Keratoconus correction	
If your child needs dental check-up or eye care	Children's glasses	50% <u>coinsurance</u> after <u>deductible</u> is met	Not covered	Coverage is limited to eyeglasses/contact lenses within 12 months following cataract surgery, correction of Keratoconus or when related to Genetic Inborn Errors of Metabolism. Prior authorization may be required.	
	Children's dental check-up	Included in office visit copayment	Not covered	None	

Excluded Services and Other Covered Services:

Services Your Plan Generall	v Does NOT Cover (Check	vour policy or	plan document for more information and a list of any	other excluded services.)

- Cosmetic Surgery
 Non-Emergency Care When Traveling Outside the U.S.
 Dental Care (Adult)
 Private-Duty Nursing
 Houtine Foot Care * Only covered when medically necessary for diabetes. See SPD for details.
 Weight Loss Programs
 Routine Eye Care (Adult)
 Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
- Acupuncture
 Bariatric Surgery
 Chiropractic Care
 Hearing Aids for school aged children
 Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>appeal</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, you may contact the Office of the Superintendent of Insurance Managed Health Care Bureau at 1-855-427-5674 or by email at mhcb.grievance@state.nm.us.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, Tricare, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes

If your <u>plan</u> doesn't meet the <u>Minimum Value Standard</u>, you may be eligible for a <u>premium tax credits</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

Para obtener asistencia en Español, llame al 1-877-752-4164.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-752-4164.

如果需要中文的帮助,请拨打这个号码 1-877-752-4164.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-752-4164.

Learn more about Presbyterian's Notice of Nondiscrimination, go to www.phs.org/nondiscrimination.aspx.

To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



Coinsurance

Limits or exclusions

The total Peg would pay is

What isn't covered

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal ca hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible \$0 Specialist \$40 Hospital (Facility) \$500		The plan's overall deductible \$0 Specialist \$40 Hospital (Facility) \$500		The plan's overall deductible Specialist Hospital (Facility)	
Other	No Charge	Other	No Charge	Other	No Charge
This EXAMPLE event includes services Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood of Specialist visit (anesthesia)		This EXAMPLE event includes service Primary care physician office visits (includes as education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose recommend)	cluding	This EXAMPLE event includes services Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy	I
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$700	Copayments	\$900	Copayments	\$500

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services

What isn't covered

\$90

\$20

\$1,010

Coinsurance

Limits or exclusions

The total Mia would pay is

What isn't covered

\$0

\$60

\$760

Coinsurance

Limits or exclusions

The total Joe would pay is

\$70

\$0

\$570